Bureau of Insurance

A Report to the Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature

Review and Evaluation of
LD 1627, an Act to Ensure Equality in Mental Health Coverage

January 8, 2002

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I. Executive Summary

The Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature directed the Bureau of Insurance to review LD 1627, An Act to Ensure Equality in Mental Health Coverage. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of MMC Enterprise Risk Consulting, Inc. (MMC) and the Maine Bureau of Insurance (the Bureau). In addition, this report includes, in Appendix F, the information required by Resolve 2001, Chapter 69, concerning cost savings to state agencies, claim denials by health insurers for mental health services, and complaints or grievances filed with health insurers or with the Bureau relating to such denials.

LD 1627 would expand the requirements of Maine's health insurance laws pertaining to coverage for the treatment of mental illness and substance abuse. The following summarizes the current laws, the changes proposed by LD 1627, and our conclusions concerning the probable impact of these changes.

Current Law

Current Maine law requires mental health benefit parity for seven listed mental illnesses for health plans sponsored by large groups (employee groups with more than 20 employees). Fee-for-service plans covering more than 20 employees and all HMO plans must also meet the minimum benefit standards established by rule for all other mental illnesses. Also, insurers and HMOs writing individual health plans are required to offer basic and standard plans that include mental health benefits established in Bureau of Insurance Rule 750.

The mandated benefit parity (for listed mental illnesses only) must be offered as an option for individual policies and employers with 20 or fewer employees. Adverse selection occurs when a greater proportion of individuals who know they will use a benefit select that coverage, driving up the average cost of the benefit. Due to the potential for adverse selection, an individual fee-for-service plan that provides benefit parity for the listed mental illnesses can add as much as $1,500 to the policyholder's monthly premium. HMO plans with benefit parity are currently available for a more reasonable premium increment, although the base premiums are about $700 per month for single coverage.

Current law requires mental health coverage to include the services of psychologists, social workers and psychiatric nurses. The law also requires health insurers and HMOs to offer optional coverage for the services of licensed counselors, including Licensed Clinical Professional Counselors (LCPCs).

For substance abuse treatment, current law requires that fee-for-service plans offered by employers with more than 20 covered employees meet a minimum level of coverage for substance abuse. Fee-for-service plans issued to individuals and to employers with 20 or fewer covered employees are exempt from these requirements. The statute mandating substance abuse coverage does not apply to HMO plans. However, all HMO plans are required to cover basic health care services that, as defined by Bureau of Insurance Rule 750, include a minimum level of benefits for substance abuse treatment. Also, insurers and HMOs writing individual health plans are required to offer basic and standard plans that include substance abuse benefits established in Rule 750.

LD 1627

The proposed bill would expand current requirements as follows:

- All health plans would be required to provide substance abuse and mental health benefits that are at least as extensive as those provided for other covered conditions. In this report, this concept is referred to as "benefit parity." Unlike the current law, this would apply to all mental illnesses[1], to substance abuse treatment in both fee-for-service and HMO plans, and to individual plans as well as groups of all sizes.

- LD 1627 would further require insurance coverage of residential treatment facilities and home health services.

- The bill would also require coverage for Licensed Clinical Professional Counselors (LCPCs) for diagnostic and treatment services.
- Finally, LD 1627 would prohibit mental health and substance abuse services from being excluded because the insured had a pre-existing condition. Currently, covered medical benefits can be excluded for up to 12 months if an individual has had a break

[1] As directed in the letter from the Joint Standing Committee on Banking and Insurance requesting this study (Appendix A), we have assumed that LD 1627 would require benefit parity for all conditions listed in the Diagnostic and Statistical Manual of Mental Health Disorders. As noted later in this report, the wording of the bill is not entirely clear on this point.

in coverage of over 90 days or if the period of recent coverage is less than 12 months. Therefore, under LD 1627 substance abuse and mental health benefits would be covered without exclusion, while physical pre-existing conditions could be excluded for up to 12 months.

Conclusions

Benefit Parity

Increased coverage for treatment of mental illness and substance abuse would undoubtedly benefit insured individuals with these disorders. However, these benefits must be weighed against their cost. The impact of LD 1627 on health insurance premiums varies by market segment and type of plan. To estimate the premium impact, the following categories of health plans were reviewed separately.

- Individual fee-for-service and managed care plans,
- Small group fee-for-service and managed care plans, and
- Large group fee-for-service and managed care plans.

The following table displays MMC's estimated premium increases associated with the mental health and substance abuse changes for the various health plan categories:

Estimated Premium Increases for LD 1627						
Health Plan	Fee-for-Service			Comprehensive Managed Care		
	SA	MH	Total	SA	MH	Total
Individual	0.28%	3.99%	4.27%	0.23%	1.32%	1.55%
Small Group	0.28%	2.86%	3.14%	0.23%	0.94%	1.17%
Large Group	0.18%	0.65%	0.83%	0.23%	0.21%	0.44%

The premium increase due to the additional coverage mandated by LD 1627 by itself would not seem likely to move health insurance purchasers to discontinue coverage. However, average annual premium increases for health insurance have been in excess of 10%, with some over 20%. The premium increase estimated for LD 1627, when combined with large renewal increases, would intensify the consumer's sensitivity to health insurance costs. The Congressional Budget Office estimates that each one-percent increase in health insurance premium drives 200,000 to 300,000 Americans off the insurance rolls. The potential increase in the uninsured population is of significant

concern in assessing the impact of LD 1627. Given that an estimated 13% of Maine residents have no health insurance, the impact of LD 1627 on the cost of health insurance and its potential to increase the number of uninsured Maine residents is an important consideration.

This is a particular concern for individual and small group plans. There would be significant premium increases for these plans since currently they are likely to have limited mental health benefits. Individuals and small employers are also the most likely to reduce benefits or discontinue health insurance in the face of rate increases, and these plans are more susceptible to adverse selection than are large group plans.

Since large group health plans already meet the current requirements for mental health parity and minimum standards for mental health and substance abuse, LD 1627 has a considerably less significant impact on large employer premiums than on premiums for small groups and individuals.

Studies have shown that effective managed care reduces the cost of mental health benefits and would substantially lower the added premium required for plans that apply managed care to mental health benefits. Our cost estimates assume that the proposed law would not limit the current effectiveness of behavioral health managed care. Clarification of the language in the bill on this point would be helpful.

Licensed Clinical Professional Counselors

MMC, the Bureau's consultant, does not believe that there would be a material impact on premiums resulting from the inclusion of Licensed Clinical Professional Counselors (LCPCs). Anthem Blue Cross and Blue Shield (Anthem) estimated an increase in premium due to the inclusion of LCPCs of 0.5%. Cigna Behavioral Health, Aetna and United Healthcare Insurance Company currently cover LCPCs.

Pre-existing Condition Exclusions

With the exception of individuals and very small groups, MMC does not believe that there would be a material financial effect if pre-existing condition exclusions were prohibited for mental health and substance abuse. Anthem indicated that only 87 out of 22,246 mental health claim denials in the year 2000 were denied due to pre-existing condition exclusions. Cigna Behavioral Health does not have pre-existing condition exclusions.

In the absence of a pre-existing condition exclusion, those who are uninsured and need care might buy individual coverage for that purpose, while under current law, they may not see that as a viable option due to the exclusion for pre-existing conditions. The same would apply to very small groups, particularly self-employed individuals. This would drive up premiums in these markets.

Residential Treatment Centers

Since some carriers in Maine already cover residential treatment centers, MMC does not believe that there would be a material cost impact due to the requirement of minimum benefits for coverage of residential treatment. Anthem, Aetna and United Healthcare Insurance Company cover residential treatment centers, while Cigna Behavioral Health does not.

II. Background

The Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature directed the Bureau of Insurance to review LD 1627, An Act to Ensure Equality in Mental Health Coverage. The review was conducted using the requirements stipulated under 24-A M.R.S.A. §2752. This review was a collaborative effort of MMC Enterprise Risk Consulting, Inc. (MMC) and the Maine Bureau of Insurance (the Bureau).

LD 1627 would amend sections of Maine law pertaining to individual and group health insurance plans and is included in Appendix A. For substance abuse and mental health treatment, LD 1627 would require that coverage be at least as comprehensive as that available for other conditions covered under a health plan. For ease of communication, the term "benefit parity" is used throughout this report to mean "coverage at least as comprehensive as that available for other conditions covered under the health plan". The proposed law would apply to all individual and group health plans.

As directed in the letter from the Joint Standing Committee on Banking and Insurance requesting this study (Appendix A), we have assumed that LD 1627 would require benefit parity for all conditions listed in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), as periodically revised. The language in the bill is not clear on this point. The definition of "mental illness" in the bill refers to the DSM only in connection with specifically listed conditions, but states that the definition is not limited to these conditions. Also, the use of the term "mental illness" in the bill, as opposed to the term "mental disorder" in the DSM, could cause confusion. While we believe the two terms are synonymous, others may interpret "mental illness" to be a subset of mental disorders. For example, some may question whether conditions such as learning, motor and communication disorders listed in the DSM and that have not typically been covered by health plans, are intended to be considered "illnesses."

LD 1627 would further require insurance coverage of residential treatment facilities and home health services, as well as coverage for Licensed Clinical Professional Counselors (LCPCs) for diagnostic and treatment services.

LD 1627 would also prohibit substance abuse and mental health benefits from being excluded from coverage because of a pre-existing condition. Currently any covered benefits can be excluded for a period of time if an individual has had a break in coverage

of over 90 days or if the period of recent coverage is less than 12 months. Therefore, coverage for substance abuse and mental health benefits would be covered under one standard, while medical pre-existing physical conditions may not be covered for up to 12 months.

Substance Abuse

Current Maine law requires fee-for-service plans offered by large employers (employers with more than 20 covered employees) to provide a minimum level of coverage for substance abuse. Fee-for-service plans issued to individuals and to small employers (employers with 20 or fewer covered employees) are exempt from this requirement. The statute mandating substance abuse coverage does not apply to HMO plans. However, all HMO plans are required to cover basic health care services that, as defined by Bureau of Insurance Rule 750, include a minimum level of benefits for substance abuse treatment. Also, individual insurers and HMOs are required to offer basic and standard health plans that include substance abuse benefits established by Rule 750.

Substance abuse has been the focus of considerable deliberation and study in Maine. The Mandated Benefits Advisory Committee issued a comprehensive report on substance abuse in June of 1992. The committee was a citizen's commission that worked with an outside consultant, state officials and a variety of interest groups. The report described 19 policy options with regard to substance abuse, including substance abuse parity. Of the nine committee members who voted, eight voted affirmatively for substance abuse parity.

In November of 1998, the Task Force on Substance Abuse issued a final report, "The Largest Hidden Tax: Substance Abuse in Maine."[2] The Task Force on Substance Abuse was a partnership of the Joint Select Committee on Substance Abuse and the Substance Abuse Services Commission. Forty-two recommendations were contained in the report, including one recommendation to amend Maine's health insurance laws to require substance abuse parity for health plans. This recommendation was incorporated into L.D. 1000, which was considered but not passed by the 119th Legislature. Another recommendation was to review the managed care procedures applied to substance abuse treatment. There were also recommendations regarding employers' drug testing and employee assistance plans.

[2] The Task Force on Substance Abuse, The Largest Hidden Tax: Substance Abuse in Maine; November 1998.

Based on the testimony provided to the Maine Legislature's Joint Standing Committee on Banking and Insurance in connection with a 1999 bill, LD 1000 – An Act to Provide Parity for Substance Abuse Treatment, the demand for this legislation was from organizations that advocate for those with substance abuse. The National Alliance for the Mentally Ill, the Maine Public Health Association, the Maine Psychological Association, Office of National Drug Control Policy, Crossroads for Women, and the Maine Association of Substance Abuse Programs submitted written testimony in favor of LD 1000. Proponents argued that the cost of early and effective treatment will be more than offset by reductions in absenteeism, the avoidance of more costly care resulting from the inadequacy or delay of treatment, criminal acts, the cost of incarceration and injuries resulting from accidents. Some argued that addiction is biologically based and, therefore, should be covered by health plans to the extent that physical conditions are covered. However, the bill was not enacted as the Legislature's Banking and Insurance Committee unanimously voted the bill "Ought Not to Pass."

Mental Health

Current Maine law requires benefit parity for the seven listed mental illnesses (schizophrenia, bipolar disorder, pervasive developmental disorder or autism, paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder) for health plans sponsored by large groups (employee groups with more than 20 employees). Fee-for-service plans covering more than 20 employees and all group HMO plans must also meet the minimum benefit standards established for all other mental health benefits in Bureau of Insurance Rule 330. Individual HMO plans must meet the minimum benefit standards established for mental health benefits in Bureau of Insurance Rule 750. Also, insurers and HMOs writing individual health plans are required to offer basic and standard plans that include mental health benefits established in Bureau of Insurance Rule 750.

Benefit parity for the seven listed mental illnesses must be offered as an option for individuals and employers with 20 or fewer employees. Adverse selection occurs when a greater proportion of individuals who know they will use a benefit select that coverage, driving up the average cost of the benefit. Due to the potential for adverse selection, an individual fee-for-service plan that provides benefit parity for the listed mental illnesses can add as much as $1,500 to the policyholder's monthly premium. Individual HMO plans with benefit parity are currently available for a more reasonable premium

increment, although the base premiums are about $700 per month for single coverage. Since for small groups, the mandated offer is to the employer and not the employee, employees are generally limited to the health plan offered by their employer.

Current law requires mental health coverage to include the services of psychologists, social workers and psychiatric nurses. The law also requires health insurers and HMOs to offer optional coverage for the services of licensed counselors, including Licensed Clinical Professional Counselors (LCPCs).

Based on the testimony provided to the Maine Legislature's Joint Standing Committee on Banking and Insurance in connection with a 1999 bill, LD 1158 – An Act to Ensure Equality in Mental Coverage for Children and Adults, the demand for this legislation was from health care professionals, organizations that advocate for health care professionals, citizens that have experienced high costs for mental health services that were not covered by insurance and organizations that advocate for those with mental health or substance abuse disorders. The Maine Medical Association, the Maine Psychological Association, the Mid-Maine Alliance for the Mentally Ill, the Association of Mental Health Services, Consumers for Affordable Health Care, and the Maine Clinical Counselors Association have submitted written testimony in favor of this legislation. Many argue that mental disorders are health problems and, therefore, should be covered by health plans to the extent that physical conditions are covered.

Opponents testifying included representatives from health carriers, the HMO Council, Maine Chamber of Commerce and The National Association of Financial Planners. They expressed concerns about the cost of the mandate.

III. Social Impact

A. Social Impact of Mandating the Benefit

1. The extent to which the treatment or service is utilized by a significant portion of the population.

Substance Abuse

A study published by the Maine Office of Substance Abuse indicates that approximately 91,000 Maine citizens are heavy alcohol users. [3] Marijuana is the most frequently used illegal drug. Although the use of other illegal drugs is increasing, there is a relatively low prevalence rate in Maine. This same study reports that in 1999, approximately 14,800 individuals were admitted for substance abuse treatment.[4]

A study done by the Joint Task Force on Substance Abuse reports that approximately 8,029 youths are in need of treatment, but that only 18% of those needing treatment receive it.[5]

Mental Health

According to the Center for Mental Health Services, between 2.8% and 5.3% of Maine residents have serious mental health conditions.[6] They also estimate that twenty-two percent of the population will need mental health care at some point in their lives. Previous testimony for LD 1158, provided by the Maine Psychological Association indicates that the incidence of anorexia and bulimia nervosa among young women in the United States is 0.5% and 2.5%, respectively. MMC research indicates that children account for approximately 50% of mental health insurance payments.

[3] Maine Office of Substance Abuse, 1999 Data Book.
[4] Ibid..
[5] The joint Task Force on Substance Abuse: Status Report on Recommendations, January 2001.
[6] Mental Health News Alert-Grant Opportunities, 1999, page 13.

2. *The extent to which the service or treatment is available to the population.*

Substance abuse and mental health treatment is available to Maine residents in a variety of settings. These include general hospitals, psychiatric hospitals, residential facilities and out-of-state facilities. Substance abuse treatment is provided by psychiatrists, physicians, licensed clinical social workers, licensed counselors, psychologists and licensed alcohol and substance abuse counselors. There are more than 50 agencies licensed in Maine to provide substance abuse services. Mental health treatment is provided by psychiatrists, physicians, licensed clinical social workers, psychologists, psychiatric nurses and other professionals. In 1995 there were 474 Licensed Clinical Professional Counselors (LCPCs) licensed in Maine.

3. *The extent to which insurance coverage for this treatment is already available.*

Insurance is currently available for the treatment of substance abuse and mental health problems. However, health plans generally provide less extensive coverage for substance abuse and mental health than would be required by benefit parity. A Kaiser Family Foundation report estimated that nearly half of all employer health plans have significant limits on in-patient and outpatient mental health treatment.

Insurance laws and rules promulgated by the Bureau of Insurance set minimum standards for substance abuse and mental health coverage in large group fee-for-service plans and all HMO plans. Plans containing these benefits must also be offered on an optional basis to small groups and individuals. Further details on these requirements are found in the Background section of this report. Insurance coverage of the services of Licensed Clinical Professional Counselors (LCPCs) is not currently required, but must be offered as an option.

4. *If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.*

Health plans providing substance abuse and mental health benefits are generally available for purchase by individuals and employers. However, health plans generally do not fully meet requirements proposed under LD 1627. Health plan limitations in combination with a person's limited financial resources could make it difficult to obtain care for an individual or covered family member who has a mental illness or who abuses or is addicted to alcohol or other substances. A national survey found that one-fourth of the 11% of the population who believed that they needed mental health or substance abuse treatment had difficulty obtaining the services, often because of cost, even when insurance was available.

The optional coverage that is available for individuals and small employers is very expensive. The selection of the optional coverage by those who know that they will use the benefit drives up the cost. Also, under group plans, since the mandated offer is to the employer and not the employee, employees are generally limited to the health plan offered by their employer.

For Medicaid eligible individuals, the Maine Association of Mental Health Services states that Maine's Medicaid program currently offers a comprehensive mental health program.

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

Coverage is available for mental health and substance abuse treatment. However, the coverage provided under an employer's health plan may not adequately cover the cost of substance abuse treatment. Financial hardship may result either from the need to pay high deductibles, coinsurance, and copayments, or from having to pay the full cost of treatment when maximum benefits are exhausted.

Although an individual can purchase a policy that provides benefit parity for the listed biologically based mental illnesses, the premium may be prohibitive. Such policies, when offered as a choice, are subject to severe adverse selection. Individuals (or individuals with family members) who have pre-existing mental illness disorders or who are prone to these disorders will elect plans with mental

health parity. Those that believe a mental illness episode is unlikely will elect not to pay the additional premium for plans that provide mental health benefit parity. A rider to add mental health parity for the listed illnesses could cost $1,500 per month. This rider would still not provide benefit parity for non-listed mental illnesses.

6. *The level of public demand and the level of demand from providers for this treatment or service.*

Substance Abuse

A study published by the Office of Substance Abuse indicates that approximately 91,000 Maine citizens are heavy alcohol users. Marijuana is the most frequently used illegal drug. Although the use of other illegal drugs is increasing, there is a relatively low prevalence rate in Maine. This same study reports that in 1999, approximately 14,800 individuals were admitted for substance abuse treatment.[7]

A study done by the Joint Task Force on Substance Abuse reports that approximately 8,029 youth are in need of treatment, but that only 18% of those needing treatment receive it.[8]

Mental Health

According to the Center for Mental Health Services, between 2.8% and 5.3% of Maine residents have serious mental health conditions. According to the Maine Association of Mental Health Services, 22% of the population is estimated to need mental health care at some point in their lives. [9] Previous testimony provided by the Maine Psychological Association indicates that the incidence of anorexia and bulimia nervosa among young women in the United States is 0.5% and 2.5%, respectively. Our research indicates that children account for approximately 50% of mental health insurance payments.

[7] Maine Office of Substance Abuse, 1999 Data Book.
[8] The Joint Task Force on Substance Abuse: Status Report on Recommendations, January 2001.
[9] Letter from Craig Phillips, president of Maine Association of Mental Health Services, March 28, 2001.

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

Based on the testimony provided to the Joint Standing Committee on Banking and Insurance, the demand for mental health parity legislation is from health care professionals, organizations that advocate for health care professionals, citizens that have experienced high costs for mental health services that were not covered by insurance and organizations that advocate for those with mental health or substance abuse disorders. The Maine Medical Association, the Maine Psychological Association, the Mid-Maine Alliance for the Mentally Ill, the Association of Mental Health Services, Consumers for Affordable Health Care and the Maine Clinical Counselors Association have submitted written testimony in favor of this legislation.

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.*

No information is available.

9. *The likelihood of meeting a consumer need as evidenced by the experience in other states.*

Appendix B gives a summary of other states' regulatory provisions for mental health and substance abuse, as well as the federal Mental Health Parity Act. Nineteen states apply mental health parity to individual health plans and seven states apply parity to self-employed individuals as part of their group insurance regulations. Eighteen states use a broad definition of mental health and twelve states include substance abuse in their mental health parity. Sixteen states exempt small businesses from benefit parity mandate. [10]

The federal Mental Health Parity Act applies only to employers with more than 50 employees. Despite its name, it does not require parity between coverage for

[10] Insurance Parity for Mental Health: Cost, Access, and Quality, NIH Publication No. 00-4787, June 2000.

mental and physical conditions. It does prohibit lower dollar limits for mental health benefits, but it does not restrict the use of limits on the number of inpatient days or outpatient visits. In 2001, the U.S. Senate passed a bill to close these loopholes; however, the House did not pass this. Legislation was enacted extending the current law, which had been scheduled to expire on December 31, 2001, for another year. Full parity is mandated for nine million federal employees pursuant to an Executive Order signed by then President Clinton, which took effect on January 1, 2001.

A Minnesota study of the financial impact of their very comprehensive law indicates premium increases due to parity to be from 1% to 2%.[11] Estimates of premium increases for New Hampshire's substance abuse and mental health parity were between 0.7% for HMOs to 1.6% for fee-for-service plans.[12] Similar analyses in Texas, Maryland and Rhode Island indicate premium increases of less than 1%. Texas reported decreases in mental health costs after parity was implemented, probably due to the use of managed care techniques.

10. The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

The Maine Department of Mental Health, Mental Retardation and Substance Abuse Services (since renamed the Department of Behavioral and Developmental Services) provided informative studies for a previous report on LD 1158, a mental health parity bill introduced in 1999, addressing the cost and benefit issues regarding substance abuse and mental health parity. No specific findings were cited.[13]

11. Alternatives to meeting the identified need.

Low-income or disabled individuals and children may qualify for Medicare and/or Medicaid benefits.

[11] Insurance for Behavioral Health Care, Office of the Legislative Auditor: State of Minnesota, February 2001.
[12] An Actuarial Analysis of Comprehensive Mental Health and Substance Abuse Benefits in the State of New Hampshire, PricewaterhouseCoopers, January 2001.
[13] Information can be found on the latest data on http://www.state.me.us/bds/osa/ostats.htm.

Public funding could be increased to support the treatment of those with low incomes and inadequate insurance coverage that do not qualify for other assistance programs.

12. Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.

The services required by LD 1627 are not inconsistent with the role of insurance and the concept of managed care. Health plans currently offer substance abuse and mental health benefits and these benefits can be subject to managed care practices. Managed care should continue to support clinical efficiency. This presumes that LD 1627 is not interpreted to preclude insurers from carving out substance abuse and mental health benefits to be administered by behavioral health managed care organizations, requiring the use of network providers and other commonly applied managed care approaches. Clarification of the language in the bill on this point would be helpful.

The provision prohibiting exclusion of pre-existing conditions is inconsistent with insurance principles. Many insurance experts believe that it is important for individuals not to wait until they need services to become insured. If insurance were only purchased by those who need services, it would be prohibitively expensive. Pre-existing condition exclusions are used to encourage individuals not to wait until they are ill to purchase health insurance. The elimination of pre-existing condition exclusions negates this important insurance principal. State and federal laws enacted in the 1990's restrict the length of time that pre-existing conditions may be excluded, but these laws recognize the need for some limitation on coverage of pre-existing conditions.

13. The impact of any social stigma attached to the benefit upon the market.

Historically, there has been a social stigma attached to substance abuse and mental health treatment. That stigma still exists. With increased knowledge of these conditions and treatment advances, this stigma has become less intense and pervasive. There is the potential that more comprehensive insurance coverage

would support more effective treatment. This may, in turn, produce more successful outcomes, which would help to reduce this social stigma.

14. The impact of this benefit upon the other benefits currently offered.

There have been studies that indicate that improving mental health has a positive effect on medical health. To the extent that that is true, improving mental health could reduce the cost of medical benefits and improve physical health. Proponents quote studies showing reduced medical costs and medical cost trends after plans add mental health benefits, including a study of 10,000 Aetna beneficiaries that showed a decrease in medical costs after including mental health benefits in their health plan.

To offset the added cost of LD 1627, employers may reduce policy benefits, increase the employees' share of the premium or discontinue providing health insurance. The Congressional Budget Office estimates that each one-percent increase in health insurance premium drives 200,000 to 300,000 Americans from the insurance rolls. Given the individual and small group premium increases estimated for LD 1627, benefit reductions or discontinuation of health insurance are likely to occur among individual and small group purchasers.

15. The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.

State law that imposes benefit mandates will heighten an employer's concern with regard to future costs and make self-insurance a more attractive alternative. The 1998 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicates that 36% percent of the large employers (500 or more employees) in the Northeast self-insure health plans. Federal legislation is being discussed that would apply similar parity requirements to self-insured plans as well as fully insured plans. Self-insured employers are not subject to LD 1627 or other state mandated benefits. They are however, subject to the federal Mental Health Parity Act discussed above.

16. The impact of making the benefit applicable to the state employee health insurance program.

Anthem Blue Cross and Blue Shield (Anthem), the current carrier for the state employee health plan, estimated that LD 1627 would increase the cost of the State Employee Health Insurance Plan by $5.04 million annually. This translates into an approximate premium increase of 3.5%-4.5%. This estimate is significantly more than MMC's estimated premium increment of .83% for large group plans. The Anthem estimate breaks down to .5% for the LCPC mandate, 2% for expansion in scope of benefits, and 1% for expansion of the definition of parity. Anthem is in the process of reviewing its estimate based on current utilization patterns.

IV. Financial Impact

B. Financial Impact of Mandating Benefits.

1. The extent to which the proposed insurance coverage would increase or decrease the cost of the service or treatment over the next five years.

LD 1627 is likely to increase the demand for substance abuse and mental health treatment. Coverage limitations may have forced individuals to curtail or forgo treatment. To the extent that coverage for treatment is increased, more individuals will be able to afford additional treatment.

2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.

In a recent report on mental health, the Surgeon General estimated that almost one-half of those receiving services for mental health did not have a diagnosable mental health problem.[14] This would indicate that, if these services were covered without managed care techniques in place, inappropriate utilization would increase. LD 1627 does not appear to preclude applying managed care or fraud detection to combat inappropriate use of services or treatment, but clarification would be helpful.

The removal of the maximums typically applied to services and benefit payments will permit longer treatment plans. Longer treatment plans are particularly important for substance abuse protocols, which often require repeated treatment before a lasting recovery is accomplished. LD 1627, in some instances, will reduce the patient co-payments applied to claim payments. This may also increase effective utilization.

Utilization of Licensed Clinical Professional Counselors (LCPCs) may increase based on past examples where insurance coverage increased utilization of services. However, if used as an alternative to more expensive providers or treatment, the

[14] Mental Health: A Report of the Surgeon General, 1999.

mandated coverage of LCPCs may not increase total medical costs.

3. *The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.*

Early diagnosis and comprehensive treatment of mental illness may reduce the need for related medical care.

Nationally, fifty-percent of substance abuse claims are for children who may start patterns of abuse that become costly if they continue into adulthood.

4. *The methods which will be instituted to manage the utilization and costs of the proposed mandate.*

LD 1627 does not preclude insurers from applying managed care and fraud detection to mental health claims.

When the Federal Office of Personnel Management (OPM) contracted for a review of the experience of large employers with mental health and substance abuse parity, the final report[15] indicated that "OPM should expect that its carriers will use coordinated, managed behavioral health techniques including:

- Adequate provider networks,
- Mechanisms for referral and treatment, such as referral units, and case managers that provide 24 hour, 7 days a week access to treatment,
- Availability of a continuum of treatment services and settings,
- Pre-certification of treatment for appropriateness of fit between patient and provider,
- Discharge coordination and planning to assure inpatient treatment is followed by appropriate outpatient care."

Studies cite the importance of a timely follow-up appointment following hospitalization and follow-up to ensure that medications are being taken as

[15] Report to the Office of Personnel Management, Washington Business Group on Health, March 2000.

directed. These services are more likely when a case manager is assigned or case management protocols are prescribed.

It is anticipated that managed care techniques similar to those in the OPM report will be instituted in Maine for plans that are not currently managing these benefits. Because of the large potential impact on health care costs and thus premiums, it would be important that managed care techniques be implemented to ensure that the appropriate amount and level of care is provided.

5. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

This legislation could increase the number of Licensed Clinical Professional Counselors (LCPCs). HMOs may be required to add LCPCs to their networks. In general, the number of providers of a service increases with the availability of reimbursement for that service.

6. *The extent to which the insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

Benefit Parity

The impact of LD 1627 on health insurance premiums varies by market segment and type of plan. To estimate the premium impact, the following categories of health plans were reviewed separately:

- Individual fee-for-service and managed care plans,
- Small group fee-for-service and managed care plans, and
- Large group fee-for-service and managed care plans.

The cost estimates in Table A summarize the calculations shown in Appendix C. For each category of policy (group size or individual), baseline mental health and substance abuse benefits were established. These benefits are intended to be representative of the coverage prior to the potential enactment of LD 1627. The

calculations are performed for comprehensive plans with minimal patient cost sharing. Although premium increments for specific health plans will vary from the estimates, the estimates should be reasonably representative of the average premium increase for the respective health plan categories.

Table A: Estimated Premium Increases for LD 1627						
Health Plan	Fee-for-Service			Comprehensive Managed Care		
	SA	MH	Total	SA	MH	Total
Individual	0.28%	3.99%	4.27%	0.23%	1.32%	1.55%
Small Group	0.28%	2.86%	3.14%	0.23%	0.94%	1.17%
Large Group	0.18%	0.65%	0.83%	0.23%	0.21%	0.44%

The data were derived from MMC's databases and client files. MMC's estimates are reasonably comparable to substance abuse and mental health parity estimates provided in published studies. Previously enacted Maine mental health mandates have moved the large group health plans closer to benefit parity than plans in other states that do not have mental health benefit parity requirements. For this reason, MMC's estimates are lower than those reported by other sources. The benefit changes required to meet the requirements of LD 1627 are more significant for individual and small group plans. Estimated increases for all plans are averages. Specific groups and individuals will have premium increases based on their current benefits, which vary significantly from plan to plan.

Mental Health

Table B outlines the mental health benefit changes underlying our cost estimates. MMC's estimate assumes that the plan currently covers the mental health benefits similar to those specified by the Maine Bureau of Insurance rules for a basic individual health plan with a $500 annual deductible. Since individual plans can be purchased with a wide array of deductible and coinsurance options, the estimated cost impact of LD 1627 on a specific plan could vary significantly from the 3.99% and 2.86% MMC estimated increase for individuals and small groups respectively. These benefits are intended to be representative of the coverage available under current law. The calculations are performed for comprehensive plans with minimal patient cost sharing. Although premium increments for specific health plans will vary from the estimates, the estimates should be reasonably representative of the average premium increases for the

respective health plan categories.

Table B Mental Health Benefit Changes Required LD 1627			
		Current Requirements	**LD 1627 Benefits**
Services Covered		Inpatient care, day treatment services and Outpatient services.	Adds home support services, residential treatment, and Licensed Clinical Professional Councilors
Pre-existing Exclusions		Cannot have pre-existing exclusions if sufficient prior coverage	Cannot have any pre-existing exclusions for mental health or substance abuse
Health Plan Classification	**Mental Health Condition**		
Individual and Small Group (1-20)	7 listed illnesses	Optional parity coverage required	Benefit parity
	Eating disorders	No requirement	Benefit parity
	Attention-deficit and disruptive behavior disorders, paraphilias, and tic disorders	No requirement	Benefit parity
	Substance Abuse	No requirement	Benefit parity
	Other mental illnesses in DSM	No requirement	Benefit parity for all DSM conditions
Large Group (20+)	7 listed illnesses	Benefit parity	Benefit parity
	Eating disorders	No requirement	Benefit parity
	Attention-deficit and disruptive behavior disorders, paraphilias, and tic disorders	No requirement	Benefit parity
	Substance Abuse	No requirement	Benefit parity
	Other mental illnesses in DSM	No requirement	Benefit parity for all DSM conditions

There are two factors that contribute to the increase in premiums. One is the increased cost due to increased scope of benefits and percentage payable by the health plan. The other is increased utilization due to the elimination of day, visit and payment maximums. Second, the higher coinsurance typically applicable to substance abuse and mental health benefits is also likely to have discouraged those who needed care.

Studies indicate that effective managed care reduces the impact of increased mental health benefits. Enriching the mental health benefits is likely to increase the frequency of use of covered services. The premium increases would be less pronounced when comprehensive benefit management is applied. This presumes that the proposed law would not limit the current effectiveness of behavioral health managed care. Accordingly, as shown in Table A, MMC estimated that the premium impact for HMO or other plans that delegate mental health benefit administration to managed care organizations that specialize in behavioral health is reduced from 3.99% to 1.32% for individual managed care plans as shown in Table A above. Similar reductions apply to group managed care plans.

Substance Abuse

Since current law does not require non-HMO individual and small group plans to meet the minimum substance abuse standard coverage required of large groups, the incremental coverage needed to meet the substance abuse benefit parity for individual and small group plans exceeds that required for large groups. Employers often shift up to 60% of the cost of rate increases to employees through reduced benefits or larger cost sharing[16], but those covered by individual insurance will feel the full increase.

For fee-for-service plans sold to large employers, the substance abuse benefit adjustments are less extensive than those required of individual and small employer plans. Current law requires large group fee-for-service plans to provide fairly comprehensive benefits for substance abuse treatment and requires benefit parity for seven listed illnesses and establishes minimum standards for other benefits. As shown in Table A, MMC estimates average premium increase

[16] PricewaterhouseCoopers, An Actuarial Analysis of Comprehensive Mental Health and Substance Abuse in the State of New Hampshire.

for substance abuse parity to be 0.18% for large employers and 0.28% for individual or small groups.

MMC expects the premiums for managed care plans to increase by 0.23% due to substance abuse parity. The increase is slightly greater than that expected for large group fee-for-service plans of 0.18%. This is due to the fact that there tends to be a greater differential between the current substance abuse benefit and that necessary for benefit parity.

Offsets

Proponents argue that the cost of early and effective treatment will be offset by reductions in more costly care resulting from the inadequacy or delay of treatment and injuries resulting from accidents. No definitive studies could be found that show the effect of these offsets.

Licensed Clinical Professional Counselors

MMC does not believe that there would be a material increase in premiums due to the inclusion of Licensed Clinical Professional Counselors (LCPCs). The requirement to reimburse LCPCs does not result in additional coverage, but only more providers to chose from. As noted below, Anthem estimated an increase in premium due to the inclusion of Licensed Clinical Professional Counselors (LCPCs). Cigna Behavioral Health, Aetna and United Healthcare Insurance Company currently cover LCPCs.

Pre-existing Condition Exclusions

With the exception of individuals and very small groups, MMC does not believe that there would be a material adverse financial effect if pre-existing condition exclusions were prohibited. Anthem indicated that only 87 out of 22,246 mental health claim denials in the year 2000 were denied due to pre-existing condition exclusions. Cigna Behavioral Health does not have pre-existing condition exclusions.

In the absence of a pre-existing condition exclusion, those who are uninsured and need care might buy individual coverage for that purpose, while under current law, they may not see that as a viable option due to the exclusion for pre-existing

conditions. The same would apply to very small groups, particularly self-employed individuals. This would drive up premiums in these markets.

Residential Treatment Centers

Since many carriers already cover residential treatment centers, MMC does not believe that there would be a material adverse financial effect due to the requirement of minimum benefits for coverage of residential treatment. Anthem covers residential treatment centers, while Cigna Behavioral Health does not. Aetna and United Healthcare Insurance Company cover subject to either a 30 day or dollar calendar year maximum.

Administrative Costs

There will also be administrative costs associated with communicating and implementing the benefit changes required by LD 1627. Given the ongoing enactment of legislation regulating health plans in Maine, these costs, hypothetically, should be included in the current premium. The percentages in Table A are based on the benefit increases. Applying these to the premium, which covers benefits and administrative costs, should be sufficient to cover the increased benefit and administrative costs associated with LD 1627.

Carriers' Estimates

Cigna Behavioral Health estimates that total premiums would increase from 1.3% to 2.3%. Anthem Blue Cross and Blue Shield's (Anthem) original estimates of the effect of LD 1627 are detailed in Table C. Anthem is in the process of updating their estimate for current plan designs and utilization patterns. United Healthcare Insurance Company estimated premiums would increase due to mental health parity for small groups by approximately 1.3% and 0.6% for large groups. They estimated an increase of 0.6% for a typical group due to substance abuse parity. Aetna and Harvard Pilgrim were unable to provide cost estimates to include in this report.

TABLE C: ESTIMATED IMPACTS OF MH/SA BILLS
(Anthem Blue Cross and Blue Shield)

LD	Topic	Avg. Mid and Large Group Impact (incl. small managed care groups)[4]	Avg. Small Group Monthly Impact [1, 3] (Indemnity)	Avg. Individual Monthly Impact[1]
482	Eating Disorders (assumes parity for these illnesses)	No Specific Adjustment Required	**0.2%-0.4%** $1.20 - $2.40	**0.2%-0.4%** $1.20-$2.40
812	Substance Abuse Parity	**0.1%**	**0.4%-0.5%** $2.40-$3.00	**0.5%-1.0%** $2.40-$3.00
1572	4 MH Conditions and SA Parity (includes expansion of scope of benefits)	**3.0%**	**6.0% - 10%** $36. - $60.	**10% - 14%**[2] $60. - $84.
	W/O expansion in scope of benefits	**2.0%**	**3.0% - 7.0%**	**6.0% - 10.0%**[2]
1627	All MH and SA Parity with LCPC mandate	**3.5% - 4.5%**	**6.0% - 11.0%** $36. - $66.	**10.0% - 15.0%**[2] $60 - $90.
	W/O LCPC mandate	**3.0% - 4.0%**	**5.5% - 10.5%**	**9.5% - 14.5%**[2]
	W/O expansion in scope of benefits or LCPC mandate	**1.0% - 2.0%**	**2.5% - 7.5%**	**5.5% - 10.5%**[2]

Footnotes:

1 Average monthly impact in dollars represents an estimated average increase per family contract per month with a current $600 premium per month.
2 The estimated individual increase DO NOT include the impact of the pre-existing condition clause.
3 Very small groups (under 20 employees) with indemnity coverage have limited coverage today. Therefore, the impact of parity benefits on their coverage is greater.
4 Very small (under 20), mid size and large managed care groups have broad mental health and substance abuse benefits. Therefore, the impact of these parity bills is more limited on their premiums.

7. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

Effective treatment of substance abuse and mental health problems may result in reduced costs for incarceration, absenteeism, accidents and severe medical conditions. Proponents argue that these savings will more than offset the cost of treatment.

No definitive studies could be found that show the effect of these offsets. For some mental illnesses, there appear to be costs savings that offset the cost of treatment. For example, depressed workers were found to have between 1.5 and 3.2 more short-term disability days in a thirty-day period than other workers had. The estimated financial cost for lost time per depressed person was between $182

and $395. These workplace costs are nearly as large as the direct cost of successful treatment.[17] Another three-year study of one large US Company reported that 61% of work absences were due to psychological problems.[18]

Numerous studies show that the cost of substance abuse treatment is a fraction of the substance abuse cost burden placed on society. For instance, the Task Force on Substance Abuse reported that the costs associated with treatment, medical care, injuries, crime, incarceration and other adverse outcomes associated with substance abuse in the State of Maine exceeds $1.2 billion each year.[19] However, those who pay the added premium for substance abuse parity may not benefit directly from the long-term societal cost savings that may result from increased coverage for substance abuse treatment. For example, a future reduction in costs for incarceration will not directly benefit a small employer who pays the increased insurance premium.

According to an article published in the Journal of the American Medical Association[20], the cost of treatment may be a fraction of the cost of incarceration, which is a common consequence of substance addiction. Nationally, average annual treatment costs by source are:

- Regular outpatient - $1,000
- Intensive outpatient - $2,500
- Methadone maintenance - $3,000
- Short-term residential - $4,400
- Long-term residential - $6,800

A year of incarceration, on average nationally, costs approximately $25,400. Uncontrolled substance abuse also leads to absenteeism, accidents and ultimately severe medical conditions.

8. *The impact on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or*

[17] Depression in the Workplace: Effects on Short–term Disability, Health Affairs, September/October 1999.
[18] Insurance Parity for Mental Health: Cost, Access, and Quality, NIH Publication No. 00-4787, June 2000.
[19] Ibid.

service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.

Health insurance premiums under LD 1627 would increase. Increased mental health coverage may produce savings in other areas. Unattended substance abuse and mental disorders may lead to otherwise avoidable costly medical care, for example treatment of liver disease in alcoholics. Early treatment may also reduce the need for more costly care resulting from and injuries resulting from accidents. The early diagnosis and treatment of mental disorders in children is particularly crucial to successful outcomes, which may avoid the need for costly treatment in later life. Treating eating disorders in young women may also avoid costly medical care. No estimate of the cost impact of these effects is available at this time.

9. *The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

See the answers to numbers 6, 7 and 8 above.

10. *The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this State.*

A study cited in the Final Report to Congress by the National Advisory Mental Health Council[21] indicates that in any one year, less than 1% of those with private insurance directly shift to the public sector. A larger percent (less than 2.2%) shift to a combination of private and public sector services. Over five years, 55% of the people in the public/private sector mix were in the cross coverage group for at least 2 years. The conclusion drawn was that the public and private sectors

[20] Physician Leadership on National Drug Policy Finds Addiction Treatment Works, JAMA, April 15, 1998.
[21] Insurance Parity for Mental Health: Cost, Access and Quality; Final Report to Congress by the National Advisory Mental Health Council, NIH Publication No. 00-4784.

are not mutually exclusive and that high cost individuals are being financed by both sectors.

A report by Mathematica[22] states that "nearly all case study informants reported they had seen no changes in state spending on mental health substance abuse as a result of parity." Informants include program officials from Maryland, Minnesota, New Hampshire and Rhode Island.

Information submitted by the Department of Behavioral and Developmental Services, the Department of Human Services and the Department of Corrections concerning cost savings is shown in Appendix F.

[22] Mathematica: Costs & Effects of Parity for Mental Health & Substance Abuse.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

1. The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.

Substance Abuse

A study[23] published in the Journal of the American Medical Association finds that addiction to elicit drugs can be treated with as much success as other chronic illnesses such as diabetes, heart disease and strokes. The medication compliance rates are show below. Medication compliance is one measure applied to assess outcomes. Medication compliance for drug addiction is abstinence or prescription drug alternatives that are then reduced until abstinence is reached.

Chronic Disease	Medication Compliance Rate
Diabetes	50%
Hypertension	30%
Adult Asthma	30%
Abstinence-oriented addiction	40%

Mental Health

Advances in drug therapy combined with psychotherapy have improved outcomes for mental health patients. Individuals, who several years ago would have required institutionalization, now with treatment, can lead normal and independent lives. A study produced by the Connecticut-Massachusetts VA

Mental Health Center noted that inpatient mental health cost fell by 30.5%. Some of this reduction is attributable to the increased prevalence of managed behavioral health care. The AHCPR Clinical Practice Guidelines for Depression states that once identified, depression can almost always be treated successfully, either with medication, psychotherapy or a combination.

Studies of the effect of parity on quality of care are inconclusive. One study of full parity plans implementing managed care found that the number of patients receiving mental-health specialty care increased, but fewer patients were hospitalized and the length of stay was reduced.[24] States including Texas, Maryland, and North Carolina implementing parity with managed care indicated an increase in the proportion of individuals using outpatient mental health services, but the number of visits did not increase and inpatient days declined. Although, the decrease in inpatient use was most evident for children, the use of specialty mental health services increased. Studies of the effect of mental health and substance abuse parity on quality measures are mixed and often inconclusive due to the lack of good quality measures.[25]

2. *If the legislation seeks to mandate coverage of an additional class of practitioners relative to those already covered.*

   a. *The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.*

      LD 1627 would mandate that the services of Licensed Clinical Professional Counselors (LCPCs) be covered for diagnostic and treatment services in the same way as other mental health professional providers. No research was found concerning the medical results of LCPCs as compared to other professionals.

[23] Physician Leadership on National Drug Policy Finds Addiction Treatment Works, JAMA, April 15, 1998.
[24] National Institute of Mental Health; Parity in Financing Mental Health Services. www.nimh.nih.gov/research/prtyrpt.
[25] Insurance Parity for Mental Health: Cost, Access, and Quality, NIH Publication No. 00-4787, June 2000.

b. The methods of the appropriate professional organization that assure clinical proficiency.

LCPCs are licensed by the Board of Counseling Professionals Licensure under the law that established the licensing procedure (Title 32, Chapter 119). The Board has educational requirements, experience requirements and requires references from professionals. Fifty-five hours of continuing education is also required for license renewal. Additionally the board has the authority to suspend, revoke, or refuse to renew a license for several reasons such as incompetence or unprofessional conduct.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations.

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.

As stated earlier in this report, benefit limitations in combination with a person's limited financial resources can make it difficult to obtain care for a persistent or serious substance abuse problem or mental illness. While LD 1627 does not offer any relief for those who are uninsured or who are covered by self-insured plans, more comprehensive mental health coverage would benefit a significant number of Maine residents. However, the impact on premiums would also be significant.

The premium increments would be the most significant for individual and small group fee-for-service plans. Individuals and small employers may elect to increase deductibles and coinsurance or discontinue coverage all together to avoid the higher cost. This market segment, individuals and small employers, is the most sensitive to premium increases and therefore the most likely to cause an increase in the number of uninsured. According to the Office of Health Policy's Chartbook on Children's Insurance Status, the chance of a child being uninsured is inversely related to the size of the firm in which his or her family adult is employed. Previously twenty-four percent of the children whose family adults are employed by firms with less than ten employees are uninsured. For family adults employed in firms with more than 1,000 employees, only 8% of the children are uninsured. After the impact of CubCare (now part of MaineCare) on uninsured children, the actual percentages have changed but the correlation between present uninsured and company size probably still holds true. In the individual market, rates have increased sharply in recent years and are already unaffordable to many.

The estimated premium increase is less significant for large employers than it is for individuals and small employers. It is likely that the need to offset the added

cost will be less urgent. For employer health plans that incorporate behavioral managed care, the estimated premium increase is less significant.

However, recent average annual premium increases for health insurance have exceeded 10% for employer groups. Individual heath premium increases have been as high as 64%.[26] The premium increase estimated for LD 1627 when combined with large renewal increases would intensify the consumer's sensitivity to health insurance costs. Given that approximately 13% of Maine residents have no health insurance, the impact of LD 1627 on the number of uninsured Maine residents is an important consideration. Numerous studies show that the cost of substance abuse treatment is a fraction of the substance abuse cost burden placed on society. However, those who pay the added premium for substance abuse parity may not benefit directly from the long-term societal cost savings that may result from increased coverage for substance abuse treatment.

Because LD 1627 could lead to increased substance abuse and mental health care, there is a premium increment for plans that currently provide limited substance abuse coverage. As a result of the current law, which imposes more stringent requirements on large groups, and the price sensitivity characteristic of the individual and small employer market segment, individual and small employer health plans are the most likely to have health plans with limited substance abuse benefits. These plans would experience the most significant premium increases. This population of individual purchasers and small group employees is also the most inclined to discontinue insurance coverage when confronted with a premium increase.

Offsetting some of the increased premium costs would be a decrease in lost work time. The estimated financial cost of depression is between $182 and $395 per depressed person for lost work time. In their letter of February 2001, the Maine Psychological Association quotes a three-year study of one large US Company as stating that 61% of work absences were due to psychological problems.

The early diagnosis and treatment of mental disorders in children is particularly crucial to successful outcomes for children. Treating eating disorders in young women is essential to avoid costly medical care and improve their capacity to

[26] White Paper: Maine's Individual Health Insurance Market, Updated January 22, 2001.

successfully function in a normal environment. Innovations in mental health treatment have produced more rapid and favorable outcomes. Proponents also argue that mental illnesses and addiction are health problems and should be covered by health plans to the extent that physical conditions are covered.

2. *The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.*

When coverage is optional it is subject to adverse selection, where potential enrollees that know their risk and the probability that they will use the benefits to enroll in health plans that cover their ailment. This drives the cost of the optional coverage up to the point where it is unaffordable.

Small employers and individuals now have the option to purchase policies with benefits similar to those required by LD 1627. Extending this as a choice to individuals is not a sound economical alternative since predominantly those in need of substance abuse or mental health treatment will elect the benefit. This adverse selection has resulted in prohibitively expensive premiums. Individuals also have the option to purchase Standard or Basic plans, which contain the level of substance abuse and mental health benefits prescribed by rule.

3. *The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.*

It is not possible to precisely measure the impact of mandated benefits. However, it is possible to estimate an outside limit, the maximum possible increase in health insurance premiums resulting from mandates. Because various mandates apply to different categories of coverage, this maximum likewise varies. The Bureau's estimates of the maximum premium increases due to existing mandates and the proposed mandate are displayed in Table D.

TABLE D – MAXIMUM PREMIUM INCREASES **Current Mandates**			
	Group (more than 20 employees)	**Group (20 or fewer employees)**	**Individuals**
Fee-for-Service Plans	8.44 %	4.34 %	4.33 %
Managed Care Plans	7.36 %	4.46 %	4.36 %
LD 1627			
Fee-for-Service Plans	0.83%	3.14 %	4.27%
Managed Care Plans	0.44%	1.17 %	1.55%
Cumulative Impact			
Fee-for-Service Plans	9.27%	7.48%	8.60%
Managed Care Plans	7.80%	5.63%	5.91%

These estimates are based on the estimated portion of claim costs that mandated benefits represent, as detailed in Appendix D. The true cost impact is less than this for two reasons:

1. Some of these services would likely be provided even in the absence of a mandate.
2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering mental health and substance abuse may reduce claims for physical conditions. Covering social workers may reduce claims for more expensive providers such as psychiatrists and psychologists. Covering chiropractic services may reduce claims for back surgery. Covering screening mammograms may reduce claims for breast cancer treatment.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time. While some studies have estimated much higher costs for mandated benefits, these studies were not based on the specific mandates applicable in Maine and therefore are not relevant. There is no indication that mandated benefits have impacted the availability of health insurance.

VII. Appendices

Appendix A:

Letter from the Committee on Banking and Insurance with Proposed Legislative Amendments

Appendix B:
Variation in State Mental Health Parity Statutes

Appendix C:
LD 1627 Benefit Cost Estimates

Appendix D:
Cumulative Impact of Mandates

Following are the estimated claim costs for the existing mandates without the reductions:

- ***Mental Health*** - The mandate applies only to groups of more than 20. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. Mental health parity for listed conditions was effective 7/1/96. The percentage has been decreasing in recent years from a high of 4.16% in 1997 to the preliminary 2000 figure of 3.13%. For 2000, this broke down as 2.9% for HMOs and 3.7% for indemnity plans. We assume the same levels going forward.

- ***Substance Abuse*** - The mandate applies only to groups of more than 20 and does not apply to HMOs. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage has shown a downward trend beginning in 1989 and continuing through 1999 when it reached 0.38%. This is probably due to utilization review, which has sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 90% of the total to about 55%. Preliminary 2000 results show a slight increase to 0.41%. We estimate the percentage to remain at about the 0.4% level.

- ***Chiropractic*** - The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the trend has been increasing since 1994. The percentage has increased from 0.84% that year to 1.46% in 1999 and a preliminary value of 1.69% in 2000. Based on this trend, we estimate 1.8% going forward.

- ***Screening Mammography*** - The amount of claims paid has been tracked since 1992 and generally has been in the range of 0.2% to 0.3%. It increased to 0.31% in 1999 and preliminary 2000 results show 0.51% which may reflect increasing utilization of this service. We estimate 0.5% going forward.

- ***Dentists*** - This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** - At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** - At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** - Our report on this mandate indicated that most of the 15 carriers surveyed said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** - Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** - No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) - This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** - Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** - The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our report does not resolve this conflict but states a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** - No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** - This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.

- ***Access to Eye Care*** – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

These costs are summarized in the following table.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts	0[1]	027
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.1%	--
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	027	--
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups of more than 20 except HMOs	0.4%	--
1975 1983 1995	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	3.7%	2.9%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	All Contracts	1.8%	1.8%
1990 1997	Benefits must be made available for screening **mammography**.	All Contracts	0.5%	0.5%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Perinatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.2%	0.2%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	.01%	0
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.1%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	.07%	.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.3%	0.3%
1998	Coverage required for **prostrate cancer screening**.	All Contracts	.07%	0
1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts		0.16%
1999	Prescription drug must include **contraceptives.**	All Contracts	0.8%	0.8%
1999	Coverage for **registered nurse first assistants.**	All Contracts	0	0
2000	Access to **clinical trials.**	All Contracts	0.46%	0.46%
2000	Access to **prescription drugs.**	All Managed Care Contracts	0	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0	0

[1] This has become a standard benefit that would be included regardless of the mandate.

2001	Access to **eye care.**	Plans with participating eye care professionals	0	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%	0.05%
Total cost for groups larger than 20:			**8.44%**	**7.36%**
Total cost for groups of 20 or fewer:			**4.34%**	**4.46%**
Total cost for individual contracts:			**4.33%**	**4.36%**

Appendix E:
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Appendix F:
Information Required by Resolve 69

Resolve 69, "to Require Further Study of the Effect and Cost Impact of Mental Illness on the State and Private Health Insurance", directed the Bureau of Insurance to include in its report on LD 1627 information concerning cost savings to state agencies. The Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Human Services and the Department of Corrections were to report to the Bureau by November 1, 2001 on estimated cost savings that would result from enactment of LD 1627.

The Resolve further directed the Bureau to include information concerning claim denials by health insurers for mental health services and concerning complaints or grievances filed with health insurers or with the Bureau relating to such denials.

I. Reports from State Agencies

Maine Department of Human Services

The Maine Department of Human Services reported an estimated 767 children under the Katie Beckett program from July 1, 2000, through June 30, 2001, for mental health services. The estimated expenditures during this time for the 1,350 children with one behavioral health service were $22,385,112. Of the 1350 children, 767 had a payment from an outside source other than Medicare with a total amount of $1,758,152. Expenditures for this program represent state and federal money. The state share for that time period was 33.88%. No specific information was given on estimated savings due to enactment of the mandate.

Maine Department of Corrections

The Maine Department of Corrections reported that there were, on average, 1,865 adult offenders and 265 juvenile offenders housed in state correctional facilities in 2001. These offenders typically do not have private insurance. Virtually all adult offenders lose their benefits. Juvenile offenders may have parents who have private health insurance, but the majority are receiving state-funded services even before the Department of Corrections receives them. If they commit the juvenile to a private psychiatric facility such as Spring Harbor for treatment, they contact the parent and ask if they have insurance. Payment through private health insurance has only happened a few times.

In addition to those in correctional facilities, there are both adult and juvenile offenders who

reside in the community but are under the supervision of the Department of Corrections. They report that if these community clients are receiving mental health or substance abuse services, they receive them through other state agencies' programs and therefore should be included in the data and cost estimates provided by the Department of Behavioral and Developmental Services or Department of Human Services.

They conclude that any cost savings that may result to the Department of Corrections from enactment of legislation mandating that private health insurance provide equality in coverage of mental illness and mental disorders, eating disorders and substance abuse for adults and children would be modest.

Maine Department of Behavioral and Developmental Services
(formerly Maine Department of Mental Health,
Mental Retardation and Substance Abuse Services)

Outpatient mental health services – July 1, 2000 through June 30, 2001 (FY01) data submitted from a sample of four community mental health agencies was used to produce statewide estimates. Crisis, outpatient, and medication management services were included in the sample.

- Aggregate number of children with insurance who were beneficiaries of state-funded services: 10,912. State dollars expended: $8,438,286.

- Aggregate number of adults with insurance who were beneficiaries of state-funded services: 36,603. State dollars expended: $9,779,681.

Inpatient mental health services – For state hospitals, data is available from the Augusta Mental Health Institute and is based on the actual number of patients admitted in FY01 with insurance, the typical private insurance payment received and the common length of stay.

- Aggregate number of adults with insurance who were beneficiaries of state-funded services: 43. State dollars expended: $523,146.60.

Data was not available from the Bangor Mental Health Institute because this information is not stored in electronic format to query.

Substance abuse services – Estimates are based on FY 01 data generated by the BDS Office of Substance Abuse using actual numbers of patients served and a formula which includes common numbers of outpatient sessions, common length of inpatient stays, and usual charges.

- Aggregate number of children and adults with insurance who were beneficiaries of state-funded services: 967. State dollars expended: $647,590.

II. Claim Denials

Table 1: Complaints received by the Bureau of Insurance from 1/1/1999 through 6/30/2001 regarding denial of claims for mental health services

Number of Complaints	**Resolution**
6	Additional Payment
32	Claim Settled
14	Company Position Upheld
2	Coverage Extended
1	Delay Resolved
11	Insufficient Information
3	Legal/Contract Issue
5	No Action Required
19	No Jurisdiction
3	Policy Reissued/Restored
6	Question of Fact
1	Referred to Proper Agency
31	Substantiated
47	Unsubstantiated
5	Other (claim reopened, etc.)
186	**Total**

Table 2: Claim denials for coverage of mental health services, and complaints and grievances for health insurers and HMOs in Maine: 1/1/99 through 6/30/01

The claims listed on the following page were denied for a variety of reasons, including provider not covered, investigational service, service determined not to be medically necessary, no authorization/referral, personal items not covered, timely filing, pre-existing condition, maximum met, deductible not met and service not covered. Denials due to timely filing and some due to lack of authorization or referral are not the member's responsibility.

Table 2

Company	Number of Claim Denials	Number of Complaints or Grievances	Resolution
Aegon Insurance Group	0	0	
Aetna US Healthcare	5,325	47*	23 upheld
Allianz Life	41	0	
Allmerica (First Allmerica)	0	0	
Alta Health & Life	0	0	
American Republic	44	0	
Anthem BCBS Indemnity	31,509	355	
Anthem BCBS Managed Care	21,212	192	128 upheld
CIGNA HealthCare	137,472	1,297	474 overturned
Conseco Medical	93	0	
Fortis Insurance	58	1	claim processed
Fortis Beneifts	0	0	
Golden Rule	388	0	
Guardian	37	8	4 decisions overturned, 2 decisions upheld
Harvard Pilgrim Healthcare	5,308	44	8 of the 13 appeals overturned
John Alden Life	45	1	claim processed with additional information
Maine Partners Health Plans	4,512	0	
MetLife	48	0	
Mutual of Omaha	74	0	
New York Life	0	0	
Pioneer Life	0	0	
Prudential	143	1	
Relistar	0	0	
State Farm	0	0	
Transamerica (formerly PFL)	100	1	satisfactory explanation given
UNICARE	225	0	
Washington National	175	0	
Total: 28 Companies	**195,951**	**1,856**	

Responses from MEGA Life & Health Insurance Company and United Healthcare Insurance Company have not been provided by the companies at this time.
*During 1999 NYLCare handled the complaints for Aetna and Aetna can only estimate that there may have been 20 complaints during that time.